DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

NOV 07 2013

Ms. Beverly D. Mackereth, Secretary
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
PO Box 8046
Harrisburg, PA 17105

RE: State Plan Amendment 13-012

Dear Ms. Mackereth:

We completed our review of the proposed amendment to section 4.19A of Pennsylvania's Title XIX Medicaid State plan submitted under transmittal number (TN) 13-012. Specifically, this amendment continues a reimbursement system for acute care general hospitals using all patient refined-diagnosis related groups by removing expiring language.

We conducted our review of your submittal according to the statutory requirements at Sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving Pennsylvania SPA 13-012 with an effective date of July 1, 2013. We are enclosing the HCFA-179 and the amended state plan pages.

If you have any questions, please call Gary Knight at (304) 347-5723.

Sincerely,

Cindy Mann
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13-012

2. STATE: Pennsylvania

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $ 21,924,654
b. FFY 2014 $ 86,470,705

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, Pages 1a and 1aa

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, Pages 1a and 1aa

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Services (APR-DRG) FY 2013 and Forward

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Review and approval authority has been delegated to the Department of Public Welfare

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Beverly D. Mackereth

14. TITLE:
Secretary of Public Welfare

15. DATE SUBMITTED:
AUG 26 2013

16. RETURN TO:
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Policy, Budget and Planning
P.O. Box 8046
Harrisburg, Pennsylvania 17105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
NOV 07 2013

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Penny Thompson

22. TITLE:
Deputy Director, Policy & Financial Mgt, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

ACUTE CARE GENERAL HOSPITAL PROSPECTIVE PAYMENT SYSTEM

Prospective Payment System

The prospective payment rate for each recipient discharged from the hospital is established by multiplying the relative value of the APR-DRG into which the patient has been classified, by the hospital specific payment rate. Payment is made based on the rate effective on the date of discharge.

METHODS USED TO ESTABLISH PROSPECTIVE RATES

Computation of Relative Values

Upon adoption of the APR-DRG classification system and for each transition to a new version of the classification system for grouping outcomes (not mapping or other front-end pre-processors), the Department will rebase Pennsylvania's (PA) Medical Assistance (MA) Fee-For-Service (FFS) relative values based on the relative values established for New York Medicaid. To establish the rebased relative values, the Department applies an adjustment factor to each New York relative value so that the PA statewide APR DRG Case Mix Index (CMI) is 1.0. The adjustment factor is determined using paid PA MA inpatient claims from the most recent full claims data year available.

Setting a Target Statewide CMI for the Implementation Year

When relative values have been rebased, the Department sets an expected statewide CMI target value for the year these relative values will be implemented. The CMI target value for the implementation year of the rebased relative values is determined by increasing the statewide CMI of 1.0 by 0.01 per year from the claims data year used for adjusting the relative values to the implementation year.

Table 1 illustrates the method the Department uses to set the target CMI for the year the rebased relative values are implemented.

Table 1

Years Elapsed from Claims Data Year used to Adjust NY Relative Values and Implementation Year of the Rebased Relative Values	Target Statewide CMI
0*	1.00
1	1.01
2	1.02
3**	1.03

*claims data year used in rebasing relative values
** Implementation Year

Setting Target CMI Growth Values and Allowable Ranges for Years Following the Year of Relative Value Implementation

For each year following the year that the rebased relative values are implemented, the Department sets a target CMI value and a CMI target range within which the actual CMI is expected to fall. The target CMI for each year following the rebased relative value implementation year is determined by adding 0.01 to the target statewide CMI of the preceding fiscal year. The target range for each target statewide CMI is plus or minus 0.01 of the target statewide CMI for the year.

Table 2 illustrates the method the Department uses to set the target CMIs and target CMI ranges.

Table 2

Year Following Rebased RVs	Projected Target CMI for Year**	Allowable Range around Target CMI**
0*	1.03	1.02-1.04
1	1.04	1.03-1.05
2	1.05	1.04-1.06
3	1.06	1.05-1.07
4	1.07	1.06-1.08
5	1.08	1.07-1.09

*Implementation year for rebased RVs
**Set based on Table 1

Beginning with the fiscal year in which the rebased relative values are implemented and using only claims to which the rebased relative values are applied, the Department will review paid claims data for each state fiscal year period to determine whether the statewide APR-DRG CMI falls within the target range. The Department will apply an adjustment (plus or minus) to each relative value effective for discharges beginning July 1 of the subsequent fiscal year to bring the statewide APR-DRG CMI within the appropriate range as specified above. For example, if the statewide APR-DRG CMI is outside the specified range for the implementation year based on an analysis of claims for the implementation year, an adjustment will be made to each relative value effective for discharges on or after July 1 of the year following the implementation year. For each subsequent fiscal year, the Department will make an adjustment to the relative values for that fiscal year after the analysis of the prior fiscal year's data has been completed. The adjustment will be effective for all discharges on or after July 1 of year being adjusted. This CMI monitoring and adjustment process will continue until there are two consecutive State fiscal years in which the statewide APR-DRG CMI falls within the target ranges specified above but will resume when relative weights are rebased as described under the heading Computation or Relative Values.

Calculation of Hospital-Specific Payment Rates

Beginning July 1, 2010, payments for inpatient hospital services under the fee-for-service prospective payment system shall be determined as follows:

(a) The Department will establish a statewide average base rate for all general acute care hospitals, except for services in a hospital unit not covered under the acute care prospective payment system. That rate will then be adjusted for a hospital's regional labor costs, teaching status, MA dependency, and average capital costs to determine the hospital's base rate.

(1) The labor cost adjustment will be the area wage index effective October 1, 2009 and used by the Centers for Medicare & Medicaid Services (CMS) under Section 1886(d) of the Social Security Act to reflect the differences in local market prices for labor. If an area wage index is below 1, it will be adjusted to 1.

(2) The teaching adjustment will be provided for hospitals that have accredited medical education programs for physicians to account more fully for factors such as severity of illness or patients requiring the specialized services provided by teaching programs and the additional costs associated with the teaching of medical residents.

(3) The Medical Assistance dependency adjustment will be provided for hospitals that serve a high percentage or number of Medical Assistance inpatient days or discharges.